LAKE COUNTY DEPARTMENT OF PUBLIC SAFETY/EMERGENCY MANAGEMENT DIVISION

Date	SPECIAL NEEDS REGISTRY FORM	Client ID

Florida and Federal law requires that information contained in your medical records be held in strict confidence and not be released without your written consent. The consent you sign on this page will remain in effect until you request in writing that your consent be withdrawn, which you may do at any time. You have a right to request and obtain a copy of this consent. This form is intended for Special Needs Registration purposes only. Dissemination, distribution, or copying of this form is strictly prohibited except for use by authorized persons. The original of this form shall be secured in a locked file.

Home Health Agency	Medical Equipment Supply Co.	Dialysis Center

Other Agency Affiliations (i.e., Children's Medical Services; Hearing, Visual, Developmental, Mental Health Services; Other Special Services)

PERSONAL INFORMATION

Last Name	First Name	MI	Social Security Number	Birthdate(Mo/Day/Yr)	Sex
			__ __ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	☐M ☐F

Ethnic Group

- ☐ African/American (B)
- ☐ Caucasian (W)
- ☐ Hispanic (H)
- ☐ Asian or Pacific Islander (AS)
- ☐ American Indian or Alaskan Native (AI/AN)
- ☐ Native Hawaiian/Other Pacific Islander (NH/PI)
- ☐ Black & White (B&W)
- ☐ American Indian or Alaskan Native & White (AI/AN&W)
- ☐ American Indian or Alaskan Native & Black (AI/AN&B)
- ☐ Asian or Pacific Islander and White (AS&W)
- ☐ 2+Races Non-Hispanic (2+NH)

Street Address	City	Zip	Phone

Mailing Address (if different)	City	Zip	Mobile Home
			☐ Yes ☐ No

Name of Subdivision, MH Park, Apt Bldg., etc.	If address is temporary, give dates	Flood Prone Area
	From: To:	☐ Yes ☐ No

Living Situation ☐ Lives Alone ☐ With Spouse ☐ With Children ☐ With Parents ☐

MEDICAL INFORMATION (*Check and complete those that apply to your medical condition.*)

- ☐ Required or Life-Sustaining Medical Equipment
  - ☐ Oxygen Concentrator
  - ☐ Portable Oxygen
  - ☐ Nebulizer
  - ☐ Respirator(Ventilator)
  - ☐ Suction Machine
  - ☐ Other _____
- ☐ Oxygen - Continuous Amount of Oxygen? _____
- ☐ Oxygen - Treatments Only
  Amount of Oxygen? _____ How Often? _____
- ☐ Oxygen - PRN (As Needed)
  Nighttime-# of hours? _____
  Daytime-# of hours? _____
  Amount used per day? _____
- ☐ Cardiac History
- ☐ Dialysis How Often? _____
- ☐ Incontinent
- ☐ Life-Sustaining Medications
- ☐ Frail
- ☐ Mobility Impaired
- ☐ Wheelchair Bound
- ☐ Bedridden
- ☐ Weight > 300 lbs.
- ☐ Hearing Impaired
- ☐ Sight Impaired
- ☐ Speech Impaired
- ☐ Memory Impaired
- ☐ Anxiety/Depression
- ☐ Emergency Alert Equipment
- ☐ DNR Order (*if so, attach copy*)
- ☐ Mental Health Impaired (*Explain*)
- ☐ Special Dietary Needs (*Explain*)
- ☐ Allergies (*List*)
- ☐ Other (*Explain*)

Primary Diagnosis:	Secondary Diagnosis:	If disability is temporary, give dates:
		From: To:

Emergency Management Use Only	Health Department Use Only
Previous Application: ☐Yes ☐No If yes, current status:	☐SN Cat 1 ☐SN Cat 2 ☐Public Shelter ☐Registry On ☐ Need More Information Initials:

EMERGENCY CONTACT INFORMATION:

First Name:	Last Name:	Relationship:	Phone:
First Name:	Last Name:	Relationship:	Phone:

PHYSICIAN/PHARMACY INFORMATION:

Physician's Last Name:	First Name:	Phone:
Pharmacy Name:		Phone:

SHELTER INFORMATION:

Will you provide your own transportation to the shelter? □ Yes □ No

If you need assistance with transportation, check one of the types of transportation you need:

- □ automobile
- □ van w/wheelchair lift
- □ stretcher

PET INFORMATION:

(If applicable, indicate how many)

- □ Cat _____
- □ Dog _____
- □ Guide Dog _____
- □ Other (Explain)_____

Name of person going with client to the shelter:	Phone:

COMMENTS:

AUTHORIZATION INFORMATION:

OPTIONAL: PREAUTHORIZATION TO ENTER HOME BY EMERGENCY PERSONNEL

I authorize emergency response personnel to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

Authorized Signature: _____

I, (*Print Name*) _____ **understand that all of my medical records are confidential, exempt from the public records law, and not to be disclosed to anyone without my consent or that of my guardian pursuant to section 455.241, Florida Statutes.**

I hereby provide my consent for the members of the Lake County Emergency Management Office to have access to the medical information contained in this form.

I understand that this form is not a reservation for the Special Needs Shelter but that my medical information will be utilized to determine/assess plans appropriate for my care and treatment during an emergency.

I further understand that only those persons who have a need to know this information, will have access to it. This release remains in effect until further notice unless revoked by me in writing.

Authorized Signature: _____ **Date:** _____

Print Name of Person Completing This Form If Other Than Client:	Contact Number:

Mail form to: Lake County Emergency Management, 315 W. Main St., PO Box 7800, Tavares, FL 32778-7800 (352) 343-9420

Revised 01/16/07